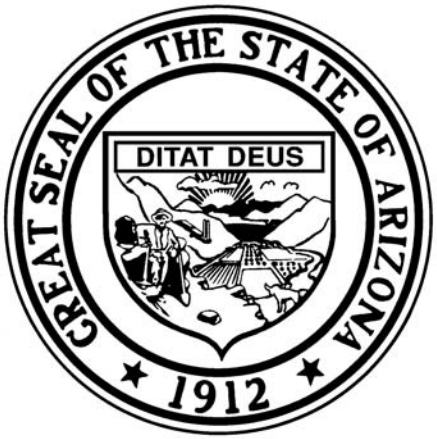
Arizona Citizen Review Panel

SIXTH ANNUAL REPORT

DECEMBER 2004

Arizona Department of Health Services
Public Health Prevention Services
Office of Women's and Children's Health



Leadership for a Healthy Arizona

Janet Napolitano, Governor
State of Arizona

Catherine R. Eden, Ph.D., Director
Arizona Department of Health Services

MISSION

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Arizona Department of Health Services
Public Health Prevention Services
Office of Women's and Children's Health
Child Fatality Review Unit
150 North 18th Avenue, Suite 320
Phoenix, Arizona 85007
(602) 542-1875

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CITIZEN REVIEW PANEL OVERVIEW

This is the sixth annual report from Arizona's Citizens Review Panels. Citizen Review Panels are members of the community who volunteer their time and energy to the betterment of the lives of Arizona's children. Volunteers from the community bring an array of perspectives, experiences, and expertise to these efforts.

BACKGROUND AND PURPOSE

Arizona's Citizen Review Panel Program was established in 1999 in response to the 1996 amendment to the Child Abuse Prevention and Treatment Act requiring states to develop and establish Citizen Review Panels. The purpose of citizen review is to determine whether state and local agencies are effectively discharging their child protection responsibilities. Panels develop recommendations for improvement of Child Protective Services through independent, unbiased reviews by panels composed of citizens, social service, legal, medical, education, and mental health professionals.

The creation of the Citizen Review Panel is an acknowledgment that protection of our children is the responsibility of the entire community, not a single agency. The entire community has a stake in protecting the safety of its children. While the primary focus of oversight is the Arizona Department of Economic Security/Division of Children, Youth and Families (ADES/DCYF), the Citizen Review Panel takes into consideration the impact of these other entities and assesses whether they support or hinder the state's efforts to protect children from abuse and neglect.

CHILD ABUSE PREVENTION AND TREATMENT ACT (CAPTA)

The Child Abuse Prevention and Treatment Act (SEC.106 [42 U.S.C. 5106a]) was enacted in 1974 to provide grants to states to support innovations in state child protective services and community-based preventive services, as well as research, training, data collection, and program evaluation. CAPTA requires states receiving a Basic State Grant to establish no less than three citizen review panels, composed of volunteer members who are broadly representative of their community, including members who have expertise in the prevention and treatment of child abuse and neglect. Each panel must meet at least once every three months and evaluate the extent to which the state agency is effectively fulfilling its child protection responsibilities in accordance with the CAPTA State Plan. In addition, panels are required to review child fatalities and near fatalities and examine other criteria important to ensure the protection of children, such as the extent to which the state child protective service system is coordinated with the foster care and adoption programs established under title IV-E of the Social Security Act.

Section 106(c)(5)(A) of CAPTA requires states to provide each citizen review panel with access to information on cases that the panel chooses to review if the information is necessary for the panel to carry out its functions under CAPTA. Report language clarifies that Congressional intent was to direct states to provide the review panels with information that the panel determines is necessary to carry out these functions.

Section 106(d) of CAPTA requires that the citizen review panels develop annual reports and make them available to the public. These reports should be completed no later than December 31st of each year and should, at a minimum, contain a summary of the panel's activities, as well as the recommendations of the panel based upon its activities and findings.

Citizen review panel members are bound by the confidentiality restrictions in section 106(c)(4)(B)(i) of CAPTA. Specifically, members and staff of a panel may not disclose identifying information about any specific child protection case to any person or government official, and may not make public other information unless authorized by state statute to do so.

Keeping Children and Families Safe Act of 2003 amended CAPTA to include the following requirements:

1. Each panel shall examine the practices (in addition to policies and procedures) of the state and local child welfare agencies.

2. Panels shall provide for public outreach and comment in order to assess the impact of current procedures and practices upon children and families in the community.

3. Each panel shall make recommendations to the state and public on improving the child protective services system.

4. The appropriate state agency is required to respond in writing no later than six months after the panel recommendations are submitted. The state agency's response must include a description of whether or how the state will incorporate the recommendations of the panel (where appropriate) to make measurable progress in improving the state child protective services system. The Arizona Department of Economic Security response to the 2003 Citizen Review Panel Report is included in Appendix A.

PROGRAM STRUCTURE

The Arizona Department of Health Services, through an interagency service agreement with the Arizona Department of Economic Security, administers Arizona's Citizen Review Panel Program. The Arizona Department of Economic Security is the state agency responsible for the provision of child protection services. During the program's planning stages, it was determined that location of this program outside the Department of Economic Security would be critical to achieve the independence necessary for an effective, objective program. Arizona Department of Health Services provides administrative support and oversees the operation of the program at the state level.

Arizona maintains three panels, which are located in Maricopa, Pima, and Yavapai counties. Appendix B lists the membership of each panel. These panels provide coverage of all counties in Arizona. Panels are responsible for review of Child Protective Service statewide policies, local procedures, pertinent data sources, and individual case records to determine compliance with CAPTA requirements and the State Plan. The State Citizen Review Panel, located in Maricopa County, serves a dual purpose of assessment of Child Protective Services and oversight of the two local panels located in Pima County and Yavapai County.

PANEL ACTIVITIES: DECEMBER 2003 THROUGH NOVEMBER 2004

MEETINGS

Each panel met on a more frequent basis than the quarterly requirement. The Pima County Citizen Review Panel met on eight occasions and completed eight case reviews. The Yavapai County Citizen Review Panel met on ten occasions and completed nine case reviews. The State Citizen Review Panel met on eight occasions and completed seven case reviews.

CASE RECORD REVIEWS

Child Protective Services selects and provides the panels with cases of fatalities, near fatalities and other cases involving allegations of high-risk maltreatment. These include cases opened as a result of a recent report and cases that are already open with Child Protective Services at the time of a new report. Cases reviewed must include a report investigated during the current state fiscal year. Reviewed cases include those in which children remain in the family's home and those in which children have been removed by Child Protective Services. Reviewed cases are not meant to be representative of all Child Protective Services cases, but rather an examination of specific steps followed during the course of an open case. During this reporting period, Arizona Citizen Review Panels completed 24 case record reviews. Twelve cases involved child fatalities due to maltreatment and 12 cases involved near fatalities and other high-risk cases of maltreatment.

Case record reviews consist of the assessment of specific activities by Child Protective Services during their involvement with families. Throughout the review, the panel identifies risk factors and determines whether Child Protective Services appropriately addressed these risks when conducting the investigation. Appendix C is the case review form completed by panels to document findings from each review. Upon completion of each review, the panel is asked the key questions of whether state and federal policies were followed and whether the panel recommends any changes in policies and procedures. The results of each review are entered into a database that is maintained by Arizona Department of Health Services.

Case reviews assess the Child Protective Service case in six stages. The stages of review include Intake/Screening, Investigation, Crisis Intervention, Investigative Finding/Determination, Case Plan Implementation, and Case Closure.

The Intake/Screening Stage involves activities performed by the Child Protective Services Child Abuse Hotline. This stage includes the identification of a risk level, the response time based on the risk, and the type of maltreatment. The panel reviews the record to determine if the hotline accurately assigned the report. The panel also determines if the hotline assigned the report to the local office in a timely manner and whether law enforcement was properly notified.

The Investigation Stage involves activities performed by Child Protective Service investigators when gathering information to assess the child's immediate safety needs and determine whether a reported or disclosed incident of maltreatment occurred. The panel reviews the record to determine if specific steps were followed during the investigation.

The Crisis Intervention Stage involves ensuring the safety of the child. The panel assesses whether Child Protective Services accurately determined if the child could safely remain in the home or if emergency removal was necessary.

The Investigative Finding/Determination Stage refers to the process of classifying a report as substantiated or unsubstantiated based on information collected and analyzed during investigation. At this stage, the panel ascertains if Child Protective Services gathered sufficient information to make a final determination and if that determination is supported by case record documentation. The panel further reviews whether relevant consultations and notifications were completed.

The Case Planning/Implementation Stage refers to activities by Child Protective Services to ensure families receive timely, appropriate services designed to address the reasons children entered the child protective service system. The panel has the task of determining whether the plans address both reducing the risk to children and enhancing family functioning. Plans should be based on an accurate family assessment, individualized to family circumstances, and modified as family circumstances change. The panel also explores community involvement with each case.

The Case Closure Stage should occur when the issues that led to the family's involvement with Child Protective Services, or subsequent issues identified by the agency during its involvement with the family, are resolved or significantly improved, or permanency has been achieved. The panel assesses whether risks were sufficiently identified and resolved prior to closure and if the closure was discussed with superiors.

CASE RECORD REVIEW FINDINGS

Records reviewed included maltreatment reports investigated by Child Protective Services after July 2003. Child Protective Services received 38,630 reports of alleged abuse or neglect from December 1, 2003, through November 30, 2004. Of those reports, 32 were fatalities or near fatalities. Child Protective Services substantiated 18 of the 32 reported cases of fatalities or near fatalities.

The Citizen Review Panel reviewed 24 cases during this reporting period. Panels determined that state and federal policies were followed in 17 cases. In the remaining seven cases, policies that were not followed are addressed within the specific stage findings. It should be noted that although problems were identified in many of the cases, there were also cases where the panel determined that the case manager did an exemplary job conducting the investigation and meeting the needs of the children and families. The Citizen Review Panel sent letters of commendation to these 11 case managers.

Appendix D provides the detailed findings from case reviews. The following summarizes the Citizen Review Panel findings for each stage.

The Intake/Screening Stage. Record reviews identified this stage as a strength of the child protection system. Panels found that actions taken by the Child Protective Services Hotline were

complete, accurate, and timely in the 21 cases reviewed and disagreed with the risk categorization in only three cases.

The Investigation Stage. In thirteen cases reviewed, investigations accurately addressed all of the following areas: the nature of the maltreatment, identification of previous injuries, the person responsible for the maltreatment, and the child's home environment. While medical evaluations were completed in a timely manner, panels determined that improvement was needed in obtaining psychological evaluations. In six of the cases reviewed, the panels determined that psychological evaluations were not completed in a timely manner. Panels determined that in 19 cases, parents and other adults relevant to the case were interviewed. When applicable, all victims were interviewed alone, away from the alleged perpetrator. Other children in the home were interviewed in nine cases, but were not interviewed in two cases. In six cases, panels determined that policies were not followed during this stage of the investigation. Concerns expressed by panel members include the use of inappropriate interpreters, lack of historic record reviews of families with numerous reports, the lack of adequate investigations of fatalities and other high-risk allegations in areas that infrequently investigate such cases, and incomplete histories provided to physicians during maltreatment assessments.

The Crisis Intervention Stage. Assessments of the adequacy of actions taken to ensure the safety of the child were mixed. In 18 cases reviewed, panels determined that appropriate, immediate actions were taken. In five cases, adequate steps were not taken to ensure the safety of the child during the investigation. In one case the panel determined this question was not applicable because the only child in the family died as result of the abuse. Concerns with this stage included erroneous or inadequate safety assessments, failure to identify risks, and failure to respond satisfactorily to violations of safety plans.

The Investigative Finding/Determination Stage. In 18 of the cases reviewed, panels determined that sufficient information was gathered during the investigation and that it supported the investigative finding. However, panels determined that documentation supported substantiation in four cases that Child Protective Services unsubstantiated. Concerns with this stage include disagreement with unsubstantiated findings, and failure by Child Protective Services to obtain pertinent records including medical records, criminal histories, and medical examiner reports.

The Case Planning/Implementation Stage. This stage applied to 15 cases that remained open after the investigation. Panels determined that overall, case planning and ongoing case management activities were appropriate and timely. In three cases the panels determined that the family needs were not adequately addressed within the case plan. Barriers to providing services included parental incarceration, parental substance abuse, and refusal to participate in services.

The Case Closure Stage. Nine cases reviewed were closed following completion of the investigation. The panels agreed with the decision to close six of the cases. In the remaining three, panels determined that unresolved risks warranted continued involvement with the family by Child Protective Services. In one case, Family Preservation closed their case in spite of additional serious reports during their involvement and without Child Protective Services' agreement. Family Preservation is a program of intensive services designed to prevent placement of children in foster care and reunify children with their families.

Family Risk Factors. Throughout the review, panel members identify specific risk factors for each case. As a result of this process, panels are able to determine if Child Protective Services adequately identified and resolved risks contributing to the maltreatment. Lack of parenting skills, mental health problems, and lack of parental motivation were the most prevalent factors for reviewed fatalities, near fatalities, and high-risk cases. Below are the total numbers of risk factors identified in the reviews.

• Lack of parenting skills	19
• Mental health problems	17
• Lack of motivation to provide adequate care	17
• Lack of physical or mental ability to provide adequate care	15
• Lack of anger control	14
• Substance abuse	14
• Domestic violence	12
• Lack of resources for adequate food/shelter/medical care/childcare	12
• Teen Parent	7
• Violence outside of home	6
• Prior removals by CPS or severance of parental rights	6
• Prior substantiated reports	5
• Prior child death	1

RECOMMENDATIONS

All findings and recommendations from the 24 cases reviewed were considered in determining the recommendations. The Citizen Review Panel respectfully submits the following recommendations:

INVESTIGATION ACTIVITIES

1. During the course of an investigation, an interpreter should never be a child, a member of the family, an acquaintance of the family, or have an interest in the outcome. The Citizen Review Panel recommends development of policy regarding the use of interpreters, including selection of appropriate interpreters.

2. It is critical to consider the family's history of reports, both substantiated and unsubstantiated, when assessing the safety of children. This recommendation was made in 2001, but continues to be a concern during reviews. The Citizen Review Panel recommends that this step be emphasized in case management training and assessed during supervisory reviews or other quality assurance reviews of investigations.

3. Complex investigations, including those involving families with numerous prior reports, may require the assistance of multidisciplinary teams. The Citizen Review Panel recommends development of multidisciplinary teams for guidance in investigations.

4. Panels noted disparities in the quality of investigations in some areas of the state that have infrequent high-risk reports. The Citizen Review Panel recommends that a consultation procedure be established to assist in the investigation of high-risk cases, particularly in areas that may have infrequent high-risk reports such as fatalities and near fatalities.

5. In order to obtain an accurate medical assessment of maltreatment, it is critical to provide available information, including history of prior injuries, medical history, and information regarding prior history of maltreatment to physicians. It is recommended that case managers routinely provide physicians with available history of prior injuries, suspected maltreatment, and medical histories.

6. During the reporting period, only six investigations by Child Protective Services were identified as cases involving near fatalities, compared to 26 cases involving fatalities. A "near fatality" is defined in CAPTA under section 106 (b)(4)(A) as “. . . an act that, as certified by a physician, places the child in serious or critical condition." The panel recommends that measures be taken to improve the accuracy of tracking investigations involving near fatalities.

CASE PLANNING IMPLEMENTATION

7. Valid assessments of family support, resources, and risk factors are essential for effective case planning. The Citizen Review Panel recommends development of policy requiring the use of tools describing the nature of relationships among family members and between families and their communities, such as a genogram or an ecomap. Due to constraints in resources, the panel limits this recommendation to reports involving high-risk maltreatment.

8. When there is a violation of a safety plan, a case should remain open until there is adequate assurance that the safety plan is followed. Safety plans that have been violated should be revised following a new safety assessment taking into account the nature and severity of the violation, as well as the likelihood of compliance.

9. When investigations involve a relative that assumes custody of a child, the relative's needs should be thoroughly addressed, particularly the need for grief therapy when there is a death.

10. Risk assessments should be completed before closure of Family Preservation services. When Family Preservation identifies additional needs or safety concerns, these should be included in their plan, rather than addressing only initially identified needs.

ADMINISTRATIVE

11. Panels identified cases in which child maltreatment was not accurately diagnosed during treatment at hospital emergency rooms and the children subsequently died as the result of maltreatment. Providing this feedback to hospital quality improvement committees could improve hospital response to maltreatment. The Citizen Review Panel recommends development of a mechanism to notify hospitals that a child has died due to maltreatment, if the hospital was known to have previously provided care for possible maltreatment to that child.

CITIZEN REVIEW PANEL OBJECTIVES FOR 2005

In 2003, Governor Janet Napolitano unveiled the "Action Plan for Reform of Arizona's Child Protection System." The plan included six main areas for reform: multi-disciplinary response to reports of abuse and neglect; statewide prevention system; clarification of mission and role of Child Protective Services; delivery of timely, effective services to children and families; provision of adequate support for both children and families served by the system and the partners who provide those services; and increased community involvement in the child welfare system. As a result of the Governor's Action Plan, several legislative changes occurred within the last year and the state has begun implementation of the plan. The Citizen Review Panel is hopeful that many problematic issues revealed in case reviews will decrease with implementation of the reform efforts. In the upcoming year, Arizona's Citizen Review Panel will incorporate elements of the action plan into case record reviews. In the case reviews, panels will determine if Child Protective Services implemented the required changes and assess the impact of the reform on the outcome of the case.

During 2004, local panels experienced difficulties obtaining complete and timely case records for review. This resulted in the cancellation of three local panel meetings, thereby decreasing the total number of cases reviewed. Citizen Review Panel staff is meeting with the Department of Economic Security to improve the process of case identification, and timely receipt of complete records.

The Citizen Review Panel will review the state CAPTA Plan, including the state's assurances of compliance with the federal requirements contained in the plan.

The Citizen Review Panel will develop a plan with the Department of Economic Security to determine areas appropriate for review by the panels such as draft policies, procedures and investigative tools.

APPENDIX A: AGENCY RESPONSE TO CITIZEN REVIEW PANEL'S 2003 RECOMMENDATIONS

RECOMMENDATIONS FOR INVESTIGATIVE INTERVIEWS

- During the course of an investigation by Child Protective Services, the investigative case manager should assess all children in the household to determine if there is any indication of maltreatment. If maltreatment is suspected, a medical professional should further evaluate the child.

- During the course of an investigation, a child should always be interviewed away from his or her parents. Child advocacy centers should be considered during an investigation, in which the home environment does not permit adequate privacy for interviews.

RESPONSE

The department agrees with these recommendations and they are addressed in existing investigation policies and procedures, and are reinforced in case manager CORE training. Where available child advocacy centers are utilized and are preferred sites for conducting interviews.

RECOMMENDATIONS FOR INVESTIGATIVE MEDICAL ASSESSMENTS

- Guidelines should be established on when a medical professional should see a child for whom there are suspicions of physical abuse, medical neglect, failure to thrive, and or developmental delay.

- The case manager should coordinate medical evaluations and communicate closely with the medical professional.

- Child Protective Services staff should have readily available medical professionals with expertise in child maltreatment to serve as consultants on investigative questions or concerns regarding medical evaluations.

RESPONSE

DCYF agrees and current policy directs staff to obtain medical examinations during an investigation under specific circumstances including to obtain a diagnosis of abuse or neglect and treatment needs. The availability of experts for consultation is frequently dependent upon the location of the child and family, and district specific interagency protocols.

RECOMMENDATIONS FOR OTHER INVESTIGATION ISSUES

- Child Protective Services should not be required by the courts to investigate cases in which there are no allegations of maltreatment. Such investigations take away valuable time needed to investigate allegations of maltreatment.

- Child Protective Services investigative case managers should have the ability to investigate reports as a team, rather than individually. It is the Panel's opinion that the quality of investigations and safety of the case managers would improve with this team approach.

- Child Protective Services and law enforcement should have timely access to the other agency when a joint investigation or immediate assistance is required.

- Information should be provided to case managers on the unexplained infant death investigative protocol used by law enforcement. Case managers should be encouraged to request the infant death checklist from law enforcement.

- When Family Preservation or Family Builders are unable to sufficiently resolve risk factors due to parents' refusal to participate or parents' inability to benefit from services, Child Protective Services should reassess the safety of the children. If safety concerns exist, a dependency petition (in-home or out-of-home) should be considered.

RESPONSE

- DCYF agrees with these recommendations. In most cases, CPS becomes involved in cases in which maltreatment has not been reported is via court order concerning delinquent or incorrigible children. DCYF provides investigation guidelines for conducting joint investigation with law enforcement, and when a CPS Specialist should conduct an investigation with another CPS Specialist. The Governor's Action Plan to Reform Arizona's CPS includes the development of formal joint investigation protocols with law enforcement. As a first responder, law enforcement and other emergency personnel are responsible for completing and providing the checklist to CPS. The development of these protocols is underway which should address and help resolve the issues identified.

- If Child Protective Services is involved with the family, current policy directs staff to conduct a Child Safety Assessment and/or a Strengths and Risk Assessment at specific times as well as when circumstances such as those identified are present. A less intrusive option enacted in the Special Legislative session, is the ability to request court oversight by filing a petition requesting In-Home Intervention.

RECOMMENDATIONS FOR CASE PLANNING ACTIVITIES

- ADES/DCYF should explore their policy regarding guardianship, to reduce risks associated with revocation of guardianship by the parent and failure to file or complete the guardianship process.

- Concerns regarding the education of a child that arise during the course of an investigation should be referred to the school district enrollment officer.

- The use of multidisciplinary teams should be encouraged for chronic, difficult cases and during investigations in which there are numerous prior reports.

- Child Protective Services case managers should be encouraged to elevate disagreements with their immediate supervisor on case decisions.

RESPONSE

- Through the dependency process, CPS staff is involved with the family until the plan of guardianship is finalized. Department policy does not reference (or encourage staff to pursue) guardianship through Probate Court as these orders are easily revoked by the parent.

- Child Protective Services case managers address a child's school attendance with the parent as part of the family assessment of strengths and risks. The parent is encouraged to cooperate with school personnel in resolving school attendance issues.

- The DCYF policy supports the use of MDTs and/or the Child and Family Teams to assess family strengths and service needs on complex cases.

- DCYF agrees. This recommendation is addressed in Supervisor training and management meetings.

APPENDIX B: PANEL MEMBERS

State Citizen Review Panel

Chair:
Mary Ellen Rimsza, M.D.
School of Health Management and Policy, Arizona State University

Members:

Lisa Barrientos
Mesa Police Department

Cindy Copp
ADES/Administration for Children, Youth & Families

Emilio Gonzales
ADES/Administration for Children, Youth & Families

Dyanne Greer, J.D.
U. S. Attorney's Office

Dave Graham
ADES/Administration for Children, Youth & Families

Simon Kottoor
Sunshine Group Home

William N. Marshall Jr., M.D.
University of Arizona College of Medicine
Department of Pediatrics

Nancy Logan
Attorney General's Office

Evelyn Roanhorse
Bureau of Indian Affairs

Beth Rosenberg
Children's Action Alliance

Lori Roehrich
Pima County Citizen Review Board

Rebecca Ruffner
Prevent Child Abuse, Inc.

Ivy Sandifer, M.D.
Physician

Ellen Stenson
Ombudsman's Office

Katrina Taylor
Public Representative

Chuck Teegarden
Pinal County Attorney's Office

Roy Teramoto, M.D.
Indian Health Services

Natalie Miles Thompson
Crisis Nursery

Princess Lucas-Wilson
ADES/Division of Developmental Disabilities

Staff:

Susan Newberry
Manager

Therese Neal
Local Team Manager

Teresa Garlington
Administrative Secretary

Pima County Citizen Review Panel

Chair:
William N. Marshall, Jr., M.D.
University of Arizona
College of Medicine, Department of Pediatrics

Coordinator:
Lori Roehrich

Members:

Darlene Abril
Court Appointed Special Advocate

David Braun
Office of the Attorney General

Diane Calahan
SO AZ Children's Advocacy Center

Christopher Corman
Foster Care Review Board
Arizona Supreme Court

Elaine Flaherty
Court Appointed Special Advocate

Lori Groenewold, M.S.W.
Tucson Medical Center

Karen Ives
Wee Care Baby Proofing

Joan Mendelson
Attorney

Kathleen Mayer
Pima County Attorney's Office

Carol Punske, M.S.W.
ADES/Administration for Children, Youth & Families

Yavapai County Citizen Review Panel

Chair:
Rebecca Ruffner
Prevent Child Abuse, Inc.

Members:

Ester Brohner
Court Appointed Special Advocate

Margaret Gregory, M.D.
Court Appointed Special Advocate

Bill Hobbs
Yavapai County Attorney's Office

Michael James
Court Appointed Special Advocate

P. J. Janik
Prescott Valley Police Department

Dawn Kimsey
ADES/Administration for Children, Youth & Families

Rodney Lewis
ADES/Administration for Children, Youth & Families

Bonnie Mari
Yavapai Regional Medical Center

Shane Reed
Yavapai County Attorney's Office

Mary Ellen Sandeen
Yavapai Regional Medical Center

APPENDIX C: CITIZEN REVIEW PANEL DATA FORM

CASE ID # _____ **DATE OF REVIEW** _____

FAMILY MEMBERS

Relationship	DOB	Gender	Race	Role	Residence Type*	County/State

REPORT HISTORY:

# of CPS Reports on Family _____; Number of prior substantiated reports on family _____
Date of initial report: _____; Date of most recent report: _____;

Report Date	Perpetrator	Victim	Allegation	Risk	Finding

Allegations:_____

_____

_____

_____

_____

STAGE 1: INTAKE AND INITIAL SCREENING

1. Was the Hotline's intake and screening response accurate and timely?
   ❑yes; ❑no; ❑n/a; ❑unknown

STAGE 2: INVESTIGATION OR ASSESSMENT

1. Investigation coordination with law enforcement: Were interagency protocols followed?
   ❑yes; ❑no; ❑n/a; ❑unknown
2. Thoroughness and accuracy of the investigation;
   A. Did the investigation address the required areas of:
      i. The existence, cause, nature and extent of child maltreatment?
         ❑yes; ❑no; ❑n/a; ❑unknown
      ii. The existence of previous injuries? ❑yes; ❑no; ❑n/a; ❑unknown
      iii. Identity of the person responsible for the maltreatment?
         ❑yes; ❑no; ❑n/a; ❑unknown
      iv. Names and conditions of other children in the home?
         ❑yes; ❑no; ❑n/a; ❑unknown
      v. The environment where the child resides?
         ❑yes; ❑no; ❑n/a; ❑unknown.
   B. Were necessary medical evaluations completed in a timely manner?
      ❑yes; ❑no; ❑n/a; ❑unknown
   C. Were necessary psychological evaluations completed in a timely manner?
      ❑yes; ❑no; ❑n/a; ❑unknown
   D. Completion and thoroughness of interviews
      i. Were parents, caregivers and the alleged abusive person interviewed?
         ❑yes; ❑no; ❑n/a; ❑unknown
      ii. Was the alleged victim interviewed alone, away from the presence of the alleged abusive person? ❑yes; ❑no; ❑n/a; ❑unknown
      iii. Were other children in the home interviewed? ❑yes; ❑no; ❑n/a; ❑unknown
      iv. Does the case record reflect compliance with the protocol or policy?
         ❑yes; ❑no; ❑n/a; ❑unknown
      v. Was the reporting source or others with knowledge of the maltreatment contacted and interviewed by the investigator? ❑yes; ❑no; ❑n/a; ❑unknown
3. Recommendations/Comments on Investigation Stage: (Consider above answers, promptness and quality of investigations, use of family advocacy center, steps to reduce trauma when answering this question.)

   _____

STAGE 3: CRISIS INTERVENTION, SAFETY ASSESSMENT, EMERGENCY PLACEMENT, AND FAMILY STABILIZATION

1. Safety Issues: Were immediate and adequate steps taken to ensure the safety of the child(ren)? ❑yes; ❑no; ❑n/a; ❑unknown
2. Comments: (Explore strengths and/or weaknesses in the following areas - safety assessment, identification of risks, services offered, and adequate safety plan.)

   _____

STAGE 4: INVESTIGATION FINDINGS/ DETERMINATION

1. Was sufficient information gathered to make a final determination of the finding? ❑yes; ❑no; ❑n/a; ❑unknown
2. Did the case record document support the finding (for example: substantiated, proposed substantiation or unsubstantiated)? ❑yes; ❑no; ❑n/a; ❑unknown
3. Comments on Report Findings/Determination Stage:

   _____

STAGE 5: CASE PLANNING/CASE PLAN IMPLEMENTATION
(Answer for cases opened for services with CPS)

1. Was the case plan developed timely and reviewed periodically in accordance with ACYF policy? ❑yes; ❑no; ❑n/a; ❑unknown
2. Were the following persons involved with the planning process:
   A. Parents/guardians? ❑ yes; ❑no; ❑n/a; ❑unknown
   B. Child(ren)? ❑ yes; ❑no; ❑n/a; ❑unknown
   C. Other relatives? ❑yes; ❑no; ❑n/a; ❑unknown
   D. Other team members? ❑yes; ❑no; ❑n/a; ❑unknown
3. Were needs of the family adequately identified and addressed in the case plan, including modifications to reflect progress or other changes in needs? ❑yes; ❑no; ❑n/a; ❑unknown
4. Was a range of services offered to the family to promote reunification or permanent placement outside the home? ❑yes; ❑no; ❑n/a; ❑unknown
5. Were there barriers to obtaining services? ❑yes; ❑no; ❑n/a; ❑unknown
6. Were timely, meaningful contacts made with the child(ren) and parent(s)? ❑yes; ❑no; ❑n/a; ❑unknown
7. Was the content/purpose of the contact or visit reflected in the records? ❑yes; ❑no; ❑n/a; ❑unknown

8. Comments on Case Planning Stage: (In addition to the above questions, consider: visitation plans with parents and siblings, medical and dental care of children, mental health treatment, educational needs and stability of out-of-home placements.)

_____

STAGE 6: CASE CLOSURE (Answer if the case was closed at the time of review)

1. Were identified risks sufficiently resolved prior to case closure?

   ❑yes; ❑no; ❑n/a; ❑unknown

   A. If no, what were the unresolved risks?

   B. In the Panel's opinion, were these risks severe enough to warrant further involvement with CPS? ❑yes; ❑no; ❑n/a; ❑unknown

2. What were the identified reasons for case closure?

   ❑ Risks were no longer severe enough to warrant further CPS involvement

   ❑ Parents/guardians refused CPS services

   ❑ Parents/guardians agreed to participate in community services

   ❑ Dependency petition was dismissed

3. Did the Panel agree with the decision to close the case? ❑yes; ❑no; ❑n/a; ❑unknown

4. Comments on case closure stage: (In addition to the above questions, consider if prior to closure this decision was discussed with the family, and if clear instructions were provided to family members on any follow-up issues or actions to take if safety concerns return?)

_____

<u>FAMILY RISK FACTORS:</u>

❑ Substance abuse

❑ Mental health problems

❑ Domestic violence

❑ History of violence outside of home

❑ Lack of physical or mental ability to provide adequate care

❑ Lack of anger control

❑ Lack of parenting skills

❑ Lack of resources for adequate food/shelter/medical care/childcare

❑ Teen Parent

❑ Prior child death

❑ Lack of motivation to provide adequate care

❑ Prior removals by CPS or severance of parental rights

❑ Prior substantiated reports

❑ Other _____

CASE REVIEW FINDINGS:

1. Were State/Federal policies followed? ❑yes; ❑no

   Comments:_____

   _____

   _____

2. Based upon this review, does the panel recommend any changes in policies and procedures?

   ❑yes; ❑no

   Comments:_____

   _____

   _____

   _____

   _____

   _____

   _____

APPENDIX D: CASE REVIEW FINDINGS

Stage 1: Intake and Initial Screening	Yes	No	Unknown	N/A
1. Was the Hotline's intake and screening response accurate and timely?	21	3	0	0
Stage 2: Investigation or Assessment	**Yes**	**No**	**Unknown**	**N/A**
1. Investigation coordination with law enforcement: Were interagency protocols followed?	16	5	3	0
2. Thoroughness and accuracy of the investigation				
A. Did the investigation address the required areas of:				
The existence, cause, nature and extent of child maltreatment?	20	3	1	0
The existence of previous injuries?	17	5	1	1
Identity of the person responsible for the maltreatment?	20	2	1	1
Names and conditions of other children in the home?	12	2	0	10
The environment where the child resides?	18	5	0	1
B. Were necessary medical evaluations completed in a timely manner?	19	0	2	3
C. Were necessary psychological evaluations completed in a timely manner?	8	6	3	7
D. Completion and thoroughness of interviews:				
Were parents, caregivers and the alleged abusive person interviewed?	19	3	1	1
Was the alleged victim interviewed alone, away from the presence of the alleged abusive person?	5	0	0	19
Were other children in the home interviewed?	9	2	0	13
Does the case record reflect compliance with the protocol or policy?	18	6	0	0
Was the reporting source or others with knowledge of the maltreatment contacted and interviewed by the investigator?	19	1	4	0
Stage 3: Crisis Intervention, Safety Assessment, Emergency Placement, And Family Stabilization	**Yes**	**No**	**Unknown**	**N/A**
1. Were immediate and adequate steps taken to ensure the safety of the child(ren)?	18	5	0	1

Stage 4: Investigation Findings	Yes	No	Unknown	N/A
1. Was sufficient information gathered to make a final determination of the finding?	18	4	2	0
2. Did the case record document support the finding?	18	4	2	0
Stage 5: Case Planning/Case Plan Implementation	**Yes**	**No**	**Unknown**	**N/A**
1. Was the case plan developed timely and reviewed periodically in accordance with ACYF policy?	14	0	1	9
2. Were the following persons involved with the planning process?				
A. Parents/guardians	15	0	0	9
B. Children	3	0	0	21
C. Other relatives	14	1	0	9
D. Other team members	10	0	3	11
3. Were needs of the family adequately identified and addressed in the case plan, including modifications to reflect progress or other changes in needs?	10	3	1	10
4. Was a range of services offered to the family to promote reunification or permanent placement outside the home?	14	1	0	9
5. Were there barriers to obtaining services?	7	7	2	8
6. Were timely, meaningful contacts made with the children and parents?	12	1	1	10
7. Was the content/purpose of the contact or visit reflected in the records?	11	1	1	11
Stage 6: Case Closure	**Yes**	**No**	**Unknown**	**N/A**
1. Were identified risks sufficiently resolved prior to case closure?	6	3	0	15
A. If yes were these risks severe enough to warrant further involvement with CPS?	4	1	0	19
2. Did the Panel agree with the decision to close the case?	6	3	0	15

To obtain further information, contact:

Susan Newberry
Child Fatality Review
Office of Women's and Children's Health
150 N. 18th Avenue, Suite 320
Phoenix, AZ 85017-3242
Phone: (602) 542-1875
Fax: (602) 542-1843
E-mail: newbers@azdhs.gov

Information about the Arizona Citizen Review Panel may be found on the Internet through the Arizona Department of Health Services at:
http://www.azdhs.gov/cfhs/azcf/index.htm

This publication can be made available in alternative format. Please contact the Child Fatality Review Unit at (602) 542-1875 (voice) or call 1-800-367-8939 (TDD).

ARIZONA DEPARTMENT OF HEALTH SERVICES
PUBLIC HEALTH PREVENTION SERVICES
OFFICE OF WOMEN AND CHILDREN'S HEALTH
CHILD FATALITY REVIEW PROGRAM
150 North 18th Avenue, Suite 320
Phoenix, Arizona 85007
(602) 542-1875

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